#### STATE OF NEVADA DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH DIVISION

BUREAU OF HEALTH CARE QUALITY AND COMPLIANCE

# PERMIT APPLICATION

(THIS APPLICATION MUST BE TYPED OR FILLED OUT LEGIBLY IN INCHALLICENSTRE
MINITIAL PERMIT CHANGE OF NAME FOR THE PERMITTED ENTITY CARSON CITY, NEVADA
ttt a barra of ownershin).
CHANGE OF OWNERSHIP (indicate date of the change of ownership):  A change of ownership application must be filed immediately in accordance with R179-09 sec. 9  A change of ownership application must be complete no more than 45 days after the change occurs.
A change of ownership application must be ruled intitlediately in accordance with the change occurs.  Change of ownership applications must be complete no more than 45 days after the change occurs.
Diald Cambral Care Conter
THE ENTITY'S D.B.A. NAME Birth Control Care Center (D.B.A. = Doing Business As)
STREET ADDRESS 872 E. SAHARA AVE  (Physical location of the entity's operation)
(Physical location of the entity's operation)
CITY LAS VegAS COUNTY CLARK STATE NO ZIP 04707
CITY LAS VeyAS COUNTY Clark STATE NV ZIP 89/04  TELEPHONE 702-733-7889 FAX 702-733-9731
Same
THE ENTITY'S MAILING ADDRESS [If different from above]
CITY COUNTY STATE ZIP
OWNER OF THE ENTITY (Applicant/Licensce) Stanley + I SAACSON 13CC, P.C.
CITY COUNTY STATE ZIP  OWNER OF THE ENTITY (Applicant/Licensee) STATE ZIP  If owner is a natural person, IS THE OWNER 21 YEARS OR OLDER? X YES \_ NO (R179-09 sec. 9)
SADAMA HUE
ADDRESS E. SAHARA AUC.  (If owner is a corporation, give corporate office address, otherwise indicate owner's address)  ZIP. 89104
CITY LAS VENAS COUNTY CLARK STATE NO ZIP 8 110
CITY LAS VeyAS COUNTY CLARK STATE NV ZIP 89/04  TELEPHONE 702-733-7889 FAX 702-733-9731
TOTAL TIONS A SET FACH OFFICER AND DIRECTOR AND
PERSON HAVING A DIRECT OR INDIRECT OWNERSHIP INTEREST.
PAUL I SAACSON, M.D. Sandi-Weigh-Office, +
Elemor P. Stanley M.O.
CT TOPOGON IN CHARGE OF THE FACILITY
NAME OF PERSON IN CHARGE OF THE FACILITY
PAUL ISAACSON, M.D.
NAME OF ACCREDITING ORGANIZATION
Pending

OWNER OF REAL PROPERTY	Donna	Marie	Kenlty
ADDRESS 872 E. SAh	and Aue		
CITY LAS VEHAS COUNTY ()	ARK	STATE NU	ZIP 89/64
PHONE 702-733-7889		FAX 700	1-733-9731

Nevada Revised Statute 449,442 requires a permit before offering services of sedation or general anesthesia to a patient. LCB File No. R179-09 authorize non-refundable fees (See Attached Fee Schedule). An application is valid for one year after the date on which the application is submitted. The application must be typed or filled out in ink. The application will not be considered complete until all required attachments are received. See the attached instruction sheet for the required attachments.

Return your completed application to an office of the:
HEALTH DIVISION
BUREAU OF HEALTH CARE QUALTIY AND COMPLIANCE
1550 E. College Pkwy. Ste. 158, Carson City, Nevada 89706

I HAVE READ THE FOREGOING QUESTIONS AND ANSWERED EACH AS INDICATED. THE ANSWERS ARE TRUE AND A COMPLETE REPRESENTATION TO THE BEST OF MY KNOWLEDGE. I HAVE READ, UNDERSTAND AND AGREE TO COMPLY WITH THE RULES AND REGULATIONS PERTAINING TO THE SPECIFIC STATUTORY TYPE OF ENTITY FOR WHICH THIS APPLICATION IS HEREIN MADE. I AUTHORIZE RELEASE OF SUCH INFORMATION AS MAY PERTAIN TO THE PURPOSE OF THIS APPLICATION.  9/24///
SIGNATURE OF REPRESENTATIVE OR OWNER DATE
PRINTED NAME OF REPRESENTATIVE OR OWNER PAUL ISAACSON, MI)
TITLE OF PERSON SIGNING APPLICATION VICE President
SUBSCRIBED AND SWORN BEFORE ME THIS 24 DAY OF September 20 10
NOTARY PUBLIC SIGNATURE Lathy Suction - allen IN AND FOR THE
COUNTY OF

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SEP 29 2010

BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY, NEVADA

PRINTED: 11/09/2012 FORM APPROVED

STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING **NVS61310PF** 11/06/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **872 E SAHARA AVE BIRTH CONTROL CARE CENTER** LAS VEGAS, NV 89104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) O 000 **Initial Comments** O 000 PROVIDERS PLAN OF This statement of deficiencies was generated as CORRECTION FOR the result of an initial state permitting survey that DEFICIENCY O 201 NAC 449.999445 (6): was conducted at your facility on 11/06/12 in accordance with Nevada Administrative Code SEE ATTACHED. (NAC), Chapter 449, Outpatient Facilities: Permit for Services of General Anesthesia, Conscious Sedation and Deep Sedation An infection risk assessment was completed. 10 patient medical charts were reviewed. The findings and conclusions of any investigation by the Health Division shall not be constructed as prohibiting any criminal or civil investigation. actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified. O 120 NAC 449.999445 (6) Sterilization, disinfection of O 120 SS=C instruments NAC 449,999445 6. Sterilization records and logs of the results of the biologic indicator test must be maintained by the outpatient facility for at least 1 year after the test is performed to ensure that the RECEIVED recommended testing and maintenance of the equipment is performed and the manufacturer's instructions regarding proper sterilization DEC 11 2012 techniques are followed. Each outpatient facility BUREAU OF HEALTHCARE QUALITY & COMPLIANCE LAS VEGAS, NV shall establish a method to track and recall instruments, items or equipment previously sterilized or disinfected if there is a failure of the biologic indicator test.

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Eleanor Powell Stankenius TITLE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Health Care Quality and Compliance

(X6) DATE

F DEFICIENCIES	y and Compliance			
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result of a state of local laws.	e-permitting inspection acility on 11/14/13, in vada Administrative Code, tient Facility.  Sesment was completed.  I charts were reviewed.  Inclusions of any investigation on shall not be construed as inal or civil investigations, ms for relief that may be y under applicable federal,	O 000	RECEIVED  DEC 0 2 2013  BUREAU OF HEALTHCARE QUALITY & COMPLIANCE LAS VEGAS, NV	
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-/ T - I find of V ii there we versitle it: Vetel	AC 449.999448 addition to the guildres and main dility which: Ensure the health picture an outpatier of the outpatier an outpatier of the outpatier an outpatier of the guildres and main dility which: Ensure the health outpatier an outpatier an outpatier of the guildres and main dility which: Ensure the health outpatier of the outpatier an outpatier of the guildres and main dility which: Ensure the health picture of the outpatier an outpatier delines and main dility which: Ensure the health picture of the outpatier delines and main dility which: Ensure the health picture of the outpatier delines and main dility which: Ensure the health picture of the outpatier delines and main dility which: Ensure the health picture of the outpatier delines and main dility which: Ensure the health picture of the outpatier delines and main dility which: Ensure the health picture of the outpatier delines and main dility which: Ensure the health picture of the outpatier delines and main dility which: Ensure the health picture of the outpatier delines and main dility which: Ensure the health picture of the outpatier delines and main dility which: Ensure the health picture of the outpatier delines and main dility which: Ensure the health picture of the outpatier delines and main dility which: Ensure the picture of the outpatier delines and main dility which: Ensure the picture of the picture of the outpatier delines and main dility which: Ensure the picture of	NVS6131OPF  **ROL CARE CENTER**  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  stial Comments  is Statement of Deficiencies was generated as esult of a state re-permitting inspection nducted in your facility on 11/14/13, in cordance with Nevada Administrative Code, apter 449, Outpatient Facility.  Infection risk assessment was completed.  The patient medical charts were reviewed.  The findings and conclusions of any investigation the Health Division shall not be construed as shibiting any criminal or civil investigations, ions or other claims for relief that may be allable to any party under applicable federal, te or local laws.  Following regulatory deficienceis were nitified.  C 449.999448 (1) Professional standards of citice  C 449.999448 (1) Professional standards of citice an outpatient facility shall establish delines and maintain policies for the outpatient facility which:  Ensure the health, safety and well-being of lents of the outpatient facility;  S REQUIREMENT is not met as evidenced  C 449.999448 addition to the guidelines established pursuant NAC 449.999441, the holder of a permit to a permit and a permit to a permit to a permit and a perm	NVS6131OPF  STREET ADDRESS, CITY, ST2 E SAHARA AVE LAS VEGAS, NV 891  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Is Statement of Deficiencies was generated as esult of a state re-permitting inspection inducted in your facility on 11/14/13, in cordance with Nevada Administrative Code, apter 449, Outpatient Facility.  Infection risk assesment was completed. The patient medical charts were reviewed. The patient med	NVS6131OPF  STREET ADDRESS, CITY, STATE, ZIP CODE  STALES AHARA AVE LAS VEGAS, NV 89104  SUMMARY STATEMENT OF DEFICIENCIES GEACH DEPRICACY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION)  Ital Comments Its Statement of Deficiencies was generated as esuit of a state re-permitting inspection inducted in your facility on 11/14/13, in condance with Nevada Administrative Code, apter 449, Outpatient Facility.  Infection risk assessment was completed, the patient medical charts were reviewed.  In findings and conclusions of any investigations, ions or other claims for relief that may be aliable to any party under applicable federal, the or local laws.  Prollowing regulatory deficienceis were intified.  C 449.999448 (1) Professional standards of cold cold cold cold cold cold cold cold

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	sterilization logs for was revealed that a	review on 11/06/12 of the biological indicat method for tracking ents was not in place	tor test, it			<b>.</b>		
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NAME OF PE	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
BIRTH CO	NTROL CARE CENTER		HARA AVE AS, NV 89104				
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	by the Division of Put shall not be construed or civil investigation,	clusions of any investigation blic and Behavioral Health d as prohibiting any criminal actions or other claims for ailable to any party under					
	There were no any re				:		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

0143

# STATE OF NEVADA DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH DIVISION

BUREAU OF HEALTH CARE QUALITY AND COMPLIANCE

### PERMIT APPLICATION

(THIS APPLICATION MUST BE TYPED OR FILLED OUT LEGIBLY IN INK)
MINITIAL PERMIT CHANGE OF NAME FOR THE PERMITTED ENTITY  RECEIVED  SEP 30 201
CHANGE OF OWNERSHIP (indicate date of the change of ownership):  A change of ownership application must be filed immediately in accordance with R179-09 sec. 9 LAS YEGAS, NEVADA  Change of ownership applications must be complete no more than 45 days after the change occurs
Woman to woman un Record Up
THE ENTITY'S D.B.A. NAME A - ALL WOMEN CARE  (D.B.A. = Doing Business As)
STREET ADDRESS 3599 S EASTERN AVE.  (Physical location of the entity's operation)
CITY LAS VEGAS COUNTY CHARKSTATE NV ZIP 89169
TELEPHONE 702 531 5400 FAX 702 731 5404
EMAIL ADDRESS: annatudenv@yahoo.com
THE ENTITY'S MAILING ADDRESS (If different from above)
CITY COUNTY STATE ZIP
OWNER OF THE ENTITY (Applicant/Licensee) DIC. ANIVA CONTINUES
If owner is a natural person, IS THE OWNER 21 YEARS OR OLDER? XYES NO (R179-09 sec. 9)
ADDRESS 5353 W DESERT INN RD. # 2073  (If owner is a corporation, give corporate office address, otherwise indicate owner's address)
CITY LAS VEGAS COUNTY CLARK STATE NV ZIP 89146
TELEPHONE 702 221 6372 FAX 702 221 6372
FOR ALL PARTNERSHIPS AND CORPORATIONS: LIST EACH OFFICER AND DIRECTOR AND PERSON HAVING A DIRECT OR INDIRECT OWNERSHIP INTEREST IN THE ENTITY OF 10% OR MORE:
WOMAN TO WOMAN GYNECOLOGY HIC
ANNA CONTOMITROS M.D 100% OWNERSHIP
NAME OF PERSON IN CHARGE OF THE FACILITY
DR. ANNA CONTOMITROS
NAME OF ACCREDITING ORGANIZATION

<del>and the state of </del>	
OWNER OF REAL PROPERTY SEEMA	ANJUM, M.D.
OWNER OF REAL PROPERTY SEENIA	AVE -
ADDRESS 3599 S EASTERN	STATE NV ZIP 89169
CITY LAS VEGASCOUNTY CLARK	STATE
PHONE 702.733 9230	FAX 702 733 9243
PHONE 1 0 0	
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Nevada Revised Statute 449.442 requires a permit before patient. LCB File No. R179-09 authorize non-refundable valid for one year after the date on which the application out in ink. The application will not be considered compattached instruction sheet for the required attachments.	
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Return your completed ap HEALTH DI	IVISION SEP 3 0 2010
BUREAU OF HEALTH CARE QU 1550 E. College Pkwy. Ste. 158	TAI TIV AND COMPLIANCE
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THAT DEATH INDERSTAND AND TOTAL	ND ANSWERED EACH AS INDICATED. THE RESENTATION TO THE BEST OF MY KNOWLEDGE. O COMPLY WITH THE RULES AND REGULATIONS TYPE OF ENTITY FOR WHICH THIS APPLICATION IS SUCH INFORMATION AS MAY PERTAIN TO THE  DATE  DATE  DOWNER  OWNER  OWNER
SUBSCRIBED AND SWORN BEFORE ME THIS	DAY OF September 20 16  IN AND FOR THE  TE OF NEVADA.  Notary Public - State of Nevada County of Clark  JAY A. ROBINSON  My Appointment Expires  No: 07-2038-1  February 9, 2011

PRINTED: 10/01/2012 **FORM APPROVED** Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING **NVS61430PF** 09/18/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3599 S EASTERN AVE A ALL WOMEN CARE LAS VEGAS, NV 89169 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG **DEFICIENCY**) **Initial Comments** O 000 O 000 This statement of deficiencies was generated as the result of the state re-permitting inspection that was completed at your facility on 9/18/12, in accordance with Chapter 449 Nevada Administrative Code for Outpatient Facilities. An Infection risk assessment was completed. Ten patient medical records were reviewed. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified. O 070 Infection Prevention Policies O 070 SS=E Section 29. Policies for prevention of infection: Each program for the prevention and control of infections and communicable diseases must include policies and procedures to prevent exposure to blood-borne and other potentially infectious pathogens, including, without limitation, policies and procedures relating to: 1. Hand hygiene, including provisions regarding the time and procedure for hand washing with

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

soap and water or the use of an alcohol-based

STATE FORM

hand rub.

(2) Use of gloves:

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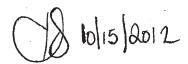
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If continuation sheet 1 of 11

OCT 17 2012

BUREAU OF HEALTHCARE QUALITY & COMPLIANCE LAS VEGAS, NV



Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING **NVS61430PF** 09/18/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3599 S EASTERN AVE **A ALL WOMEN CARE** Wrong addrews LAS VEGAS, NV 89169 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) O 070 Continued From page 1 O 070 The proper use of medical gloves, including, without limitation, a requirement that each person who works at the outpatient facility must wear medical gloves when the person: (a) Anticipates coming in contact with blood or bodily fluids: (b) Handles contaminated instruments, items and equipment; (c) Handles biological waste or biologically contaminated waste that may cause harm to humans, animals or plants; (d) Handles linens potentially contaminated with biological waste or biologically contaminated waste that may cause harm to humans, animals or plants: and (e) Performs housekeeping activities or cleans contaminated surfaces. (3) Safe injection practices: Safe injection practices to prevent the contamination of equipment used for injections and medication, including, without limitation, a requirement that a new sterile needle and new sterile syringe be used for each patient and not used for more than one patient. (4) Handling of sharps: The proper handling of sharp instruments and the disposal of sharp instruments, which must be consistent with the standards developed by the Occupational Safety and Health Administration of the United States Department of Labor for the handling and disposal of such instruments. (5) Access of medications in vials: Techniques for accessing a vial of medication, which must comply with the requirements set forth in section 30 of this regulation, If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

VZWD11

10/15/2012

If continuation sheet 2 of 11

Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING **NVS61430PF** 09/18/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE A ALL WOMEN CARE 3599 S EASTERN AVE LAS VEGAS, NV 89169 Wrong Addrew (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ın (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) O 070 Continued From page 2 O 070 (6) Infusion Medications and tubing: The infusion of intravenous medications, which must provide, without limitation, that intravenous tubing and fluid bags or bottles are not to be used for more than one patient. (7) Sterilization and disinfection of medical equipment: The proper sterilization and disinfection of all medical equipment, instruments and devices. Those policies and procedures must, at a minimum, require the outpatient facility to: (a) Sterilize or ascertain the sterility of items that enter sterile tissue or the vascular system, including, without limitation, surgical instruments, endoscopes, endoscopic accessories, catheters, needles and probes used for ultrasounds; (b) Perform high-level disinfection of reusable items that come in contact with nonintact skin or mucous membranes, including, without limitation, respiratory therapy equipment, anesthesia equipment, bronchoscopes and gastrointestinal endoscopes; and (c) Perform low-level disinfection of reusable items that come in contact with only intact skin, including, without limitation, tourniquets, blood pressure cuffs, linens, stands that are used to hold medical instruments and other furnishings. (8) Handling of equipment: The proper handling of equipment, instruments and devices. Those policies and procedures must, at a minimum, require the outpatient facility (a) Sterilize and disinfect reusable items as described in subsection 7; (b) Properly dispose of single-use equipment, instruments and devices after use, if the outpatient facility has decided not to have the equipment, instruments or devices reprocessed; If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies. STATE FORM

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If continuation sheet 3 of 11

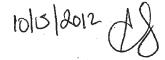
Bureau of Health Care Quality and Compliance (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 09/18/2012 **NVS61430PF** NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3599 S EASTERN AVE A ALL WOMEN CARE Woman LAS VEGAS, NV 89169 PROVIDER'S PLAN OF CORRECTION (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) O 070 | Continued From page 3 O 070 and (c) Ensure that: (1) All equipment, instruments and devices that may be reprocessed are reprocessed only by a third-party processor approved by the United States Food and Drug Administration; and (2) No equipment, instruments or devices that may be reprocessed are reprocessed at the outpatient facility. (9) The proper handling and disposal of medical waste and specimens. (10) The proper cleaning and disinfection of all areas in which patient care is provided. (11) The proper maintenance of a clean and sanitary environment. (12) Infection identification and tracking: The identification and reporting of the development and transmission of infections and communicable diseases, including, without limitation, the method by which the outpatient facility must: (a) Track and document the development and transmission of infections and communicable diseases which are related to the medical procedures performed at the outpatient facility: (b) Report the development and transmission of infections and communicable diseases as required by federal, state and local laws; and (c) Identify and address trends in such developments and transmissions of infections and communicable diseases. (13) The care of patients with a communicable disease, including, without limitation, patients who are known to have a communicable disease at the time of arrival at the outpatient facility and

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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if continuation sheet 4 of 11



Bureau of Health Care Quality and Compliance (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION A. BUILDING 09/18/2012 B. WING NVS61430PF STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3599 S EASTERN AVE Wong address LAS VEGAS, NV 89169 A ALL WOMEN CARE PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES CROSS-REFERENCED TO THE APPROPRIATE PREFIX (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG 0 070 Continued From page 4 0 070 patients who are found to have a communicable disease during the course of treatment at the outpatient facility. (14) The screening for communicable diseases as described in NAC 441A.375 of all employees and of all persons under contract with the outpatient facility who work at the facility and have exposure to patients at the facility. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to assure post procedures were monitored by the facility for 10 of 10 patient records reviewed. Seepage 23 of our Planof 10/15/12 Conections Findings include: Ten patient medical records were reviewed. There was no documented evidence the patient's received a follow up telephone call to identify any signs and symptoms of infection. The infection control Registered Nurse (RN) was unable to provide documentation of tracking post procedural infections. On 9/18/12 at 4:10 PM, the infection control RN acknowledged there was no written documentation of tracking of post procedural infections. Severity: 2 Scope: 2 O 090 O 090 Surgical Equipment Sterilization SS=F If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies. If continuation sheet 5 of 11

STATE FORM

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Bureau of Health Care Quality and Compliance  TATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIES IDENTIFICATION NUMBER OF CORRECTION			ER/CLIA IMBER:	(X2) MULTIPLE C	ONSTRUCTION	steered to the steeler	(X3) DATE SUI COMPLET	B/2012	NAMA
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If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies. STATE FORM

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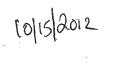
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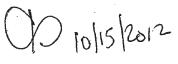
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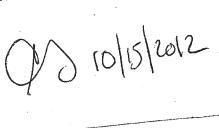


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Employee #2 was hired 7/16/12. The employee received the first step TB skin test on 6/19/12. There was no documented evidence the employee received a second-step TB skin test.  Employee #3 was hired 8/27/12. The employee received the first step TB skin test on 8/24/12. There was no documented evidence the employee received a second-step TB skin test.  Employee #1 had a two step TB skin test.  Employee #1 had a two step TB skin test on 3/3/11 and 3/10/11. There was no documented evidence an annual TB test was administered.  On 9/18/12 at 3:50 PM, the Infection Control Nurse acknowledged the TB skin tests were not administered per policy.  Screening employees for communicable disease policy (no identified number) documented:  "If the employee has only completed the first step of a 2-step Mantoux within the preceding step of a 2-step Mantoux within the preceding Mantoux or other single-step tuberculosis Mantoux or other single-step tuberculosis screening test will be administered"  There was no documented evidence found in the Screening employees for communicable disease policy addressing the annual TB skin test requirement.			- una includ	le:	-1-100						-	
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STATE OF NEVADA DEPARTMENT OF HEALTH AND HUMAN SERVICES DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

## PERMIT APPLICATION

(THIS APPLICATION MUST BE TYPED OR FILLED OUT LEGIBLY IN INK

INITIAL PERMIT CHANGE OF NAME FOR THE PERMITTED ENTITY  BUREAU OF HEALTH CARE  CARSON COMPLY CARE
CHANGE OF OWNERSHIP (indicate date of the change of ownership):  A change of ownership application must be filed immediately in accordance with R179-09 sec. 9  Change of ownership applications must be complete no more than 45 days after the change occurs.
THE ENTITY'S D.B.A. NAME Safe and Sound for Women Inc (D.B.A. = Doing Business As)
STREET ADDRESS 3131 La Canada # 110 (Physical location of the entity's operation)
CITY Las Vegas COUNTY CLARK STATE NV ZIP 89169 TELEPHONE 702-221-7233 FAX 702-836-3171
TELEPHONE 702-221-7233 FAX 702-836-31 1
ENTITY'S EMAIL ADDRESS: DRMAZZ @ ATT, NET
THE ENTITY'S MAILING ADDRESS
CITY STATE ZIP
OWNER OF THE ENTITY (Applicant/Licensee) HARTMAN, SPIRTOS, MAZZORANA
If owner is a natural person, IS THE OWNER 21 YEARS OR OLDER? YES NO (R179-09 sec. 9)
ADDRESS 3131 La Canada # 116  (If owner is a corporation, give corporate office address, otherwise indicate owner's address)  CITY Las Vesas County CIARK STATE NV ZIP 89169
TELEPHONE 702-221-7233 FAX 7028363171
FOR ALL PARTNERSHIPS AND CORPORATIONS: LIST EACH OFFICER AND DIRECTOR AND PERSON HAVING A DIRECT OR INDIRECT OWNERSHIP INTEREST IN THE ENTITY OF 10%
Dr Craig Hartman, Dr Nick Spirtos, Dr Vicki Mazzorana
NAME OF PERSON IN CHARGE OF THE FACILITY
Dr Craig Hartman
NAME OF ACCREDITING ORGANIZATION
NONE - PENDING

OWNER OF REAL PROPERTY DOCTORS Pavillion at Sunvise
ADDRESS 5575 POLATIS Ave Suite C
CITY LASVEGAS COUNTY CLARK STATE NU ZIP 89/18
PHONE 702-204-7285 FAX
Paul Reechen

Nevada Revised Statute 449.442 requires a permit before offering services of sedation or general anesthesia to a patient. LCB File No. R179-09 authorize non-refundable fees (See Attached Fee Schedule). An application is valid for one year after the date on which the application is submitted. The application must be typed or filled out in ink. The application will not be considered complete until all required attachments are received. See the attached instruction sheet for the required attachments.

Return your completed application to an office of the: DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

727 Fairview Dr. Ste. E Carson City, NV. 89701 RECEIVED

MAR 1 7 2014

Check Only One Box: If no selection is made, notices may be sent through email.

BUREAU OF HEALTH GARE QUALITY & COMPLIANCE GARSON GITY NV

I prefer to receive notices through email.

☐ I prefer to receive notices through the U.S. Mail.

Due to the high cost of mailings and the desire to keep licensure fees down, notices may not be physically mailed to your facility or agency unless you note above that you prefer to receive notices through the U.S. mail.

I HAVE READ THE FOREGOING QUESTIONS AND ANSWERED EACH AS INDICATED. THE ANSWERS ARE TRUE AND A COMPLETE REPRESENTATION TO THE BEST OF MY KNOWLEDGE. I HAVE READ, UNDERSTAND AND AGREE TO COMPLY WITH THE RULES AND REGULATIONS PERTAINING TO THE SPECIFIC STATUTORY TYPE OF ENTITY FOR WHICH THIS APPLICATION IS HEREIN MADE. I AUTHORIZE RELEASE OF SUCH INFORMATION AS MAY PERTAIN TO THE PURPOSE OF THIS APPLICATION.

PRINTED NAME OF REPRESENTATIVE OR OWNER WICK MAZZORANA MD PC

TITLE OF PERSON SIGNING APPLICATION Secretary Treasurer

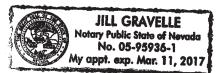
SUBSCRIBED AND SWORN BEFOREME THIS DAY OF MACCON

NOTARY PUBLIC SIGNATURE SUCCESSIONATURE IN AND FOR THE

COUNTY OF CLACK, STATE OF NEVADA.

Outpatient Facility Application.doc

Posted 07/10/13



PRINTED: 10/19/2015 FORM APPROVED

Division of Public and Behavioral Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION :	(X3) DATE COMF	SURVEY PLETED
		NVS7982OPF	B. WING		09/0	04/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
SAFE AN	ID SOUND FOR WON	IEN. INC	ANADA #11 AS, NV 891			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
O 000	Initial Comments		O 000			
	the result of an initi was conducted at y finalized on 9/4/14, Administrative Cod Outpatient Facilities General Anesthesia Deep Sedation.	leficiencies was generated as al State Permitting Survey that your facility on 8/29/14 and in accordance with Nevada e (NAC), Chapter 449, s: Permit for Services of a, Conscious Sedation and				
	The findings and co by the Division of P shall not be constru or civil investigation	ecord was reviewed.  onclusions of any investigation relation and Behavioral Health used as prohibiting any criminal as, actions or other claims for vailable to any party under state or local laws.				
		nd in compliance with the patient Facilities, please retain ecords.				

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies. LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

XQWV11